GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health
Health Professional Licensing Administration

SUPPLEMENTAL INFORMATION
(PLEASE PRINT IN INK OR TYPE)

NAME (Last, First, Middle Initial) _____

ADDRESS (Street, City, State, Zip) _____

Type of License _____

Date of Application _____

This Form Should be completed By:
Occupational Therapist
Physical Therapist
Practical Nurse
Psychologist
Registered Nurse

TO BE COMPLETED BY ALL APPLICANTS

1. Are you addicted to drugs, chronic or persistent inebriety, afflicted with contagious disease or physical or mental disability?
   ☐ Yes ☐ No If answer is yes, attach explanation.
2. References. List names and addresses of three responsible persons (other than relatives, instructors or employers) who have known you for at last one year and can attest to your character.

Name	Address (including zip code)	Title & Position

TO BE COMPLETED BY REGISTERED NURSE APPLICANTS

Certification for State Board Examination (to be completed by School of Nursing).
This if to certify that _____, a student in the
Name of Applicant
_____ School of Nursing will have complete the nursing program and will have been awarded the diploma of the School of Nursing on or before _____; also, that said candidate has a passing grade in each subject and will have met all other requirements for admission to the State Board Examination as outlined in the Nurses' Examining requirements and standards for accredited Schools of Nursing in the District of Columbia by the time his/her course is completed.

On behalf of the faculty of the _____ School of Nursing. I recommend the foregoing applicant for admission to the State Board Examination on the dates indicated.

(SCHOOL SEAL) _____ _____
Dean or Registrar Date

Have you ever taken an examination for certification as a registered nurse? ☐ Yes ☐ No If "Yes", give date and place of examination and whether you passed or failed.

TO BE COMPLETED BY PRACTICAL NURSE APPLICANTS

Certification for State Board Examination (to be completed by School of Practical Nursing).
This if to certify that _____, a student in the
Name of Applicant
_____ School of Practical Nursing program and will have/has been awarded the diploma of the School on or before _____; also, that said candidat has a passing grade in each subject and will have/has met all other requirements for Sate Board Examinations as outlined in th Practical Nurses' Examining Boards requirements and standards for the accredited Schools of Practical Nursing in the District Columbia by the time his/her course is completed on _____ . I recommen the foregoing applicant for admission to the State Board Examination.

(SCHOOL SEAL) _____ _____
Dean or Registrar Date

TO BE COMPLETED BY PHYSICAL THERAPIST, OCCUPATIONAL THERAPIST & PSYCHOLOGIST APPLICANTS

Have you ever taken the NPTE or AOTA examination? ☐ Yes ☐ No If yes, what State?_____
Examination Date _____ Where your scores accepted as passing by that State? ☐ Yes ☐ No
Are you certified by AOTA? ☐ Yes ☐ No Certification Number _____

Experience:

	Name of Employer	Address	Position	From - To
1.				
2.				
3.				

If you practice has been limited to a specialty, state which one:
_____

From _____ To _____

TO BE COMPLETED BY OCCUPATIONAL THERAPIST AND PSYCHOLOGIST APPLICANTS

Internship(s). Give name of hospital/institution, address and period(s) of internship.

_____
_____